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OVERVIEW OF PRESENT LAW, PROPOSALS, AND ISSUES RELATING TO EMPLOYER-PROVIDED RETIREE HEALTH INSURANCE

SCHEDULED FOR A HEARING

BEFORE THE

SUBCOMMITTEE ON OVERSIGHT

OF THE

COMMITTEE ON WAYS AND MEANS

ON SEPTEMBER 15, 1988

PREPARED BY THE STAFF

OF THE

JOINT COMMITTEE ON TAXATION

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INTRODUCTION

The Subcommittee on Oversight of the House Committee on Ways and Means has scheduled a public hearing on September 15, 1988, on employer-provided retiree health insurance issues.

The Subcommitte hearing will consider: (1) the availability of employer-provided retiree sponsored health insurance; (2) the liability associated with existing retiree health benefits; and (3) the factors impacting on the continued availability of retiree health benefits. In addition, the Subcommittee will review what steps, if any, the Federal Government should take to improve the funding, availability, and security of retiree health benefits.

This pamphlet,[1] prepared by the staff of the Joint Committee on Taxation, provides an overview of present-law tax rules, proposals, and issues relating to employer-provided retiree health insurance.

[1] This pamphlet may be cited as follows: Joint Committee on Taxation, *Overview of Present Law, Proposals, and Issues Relating to Employer-Provided Retiree Health Insurance* (JCS-15-88), September 13, 1988.

I. OVERVIEW

Post-retirement medical benefit plans (i.e., retiree health plans) are plans maintained by employers to pay for all or a portion of the medical costs of retired or former employees of the employer (and possibly also their dependents) either directly or by the purchase of insurance. Generally, the employer finances all or a significant portion of the cost of this benefit for the retiree. The cost for both the employer and the beneficiary of these retiree health benefits depends greatly on the age of the beneficiary. For retirees under the age of 65, the employer-provided health benefit normally represents the primary source of medical insurance because such retirees generally are not eligible for Medicare benefits. The cost of insuring an early retiree usually exceeds the average cost of insuring a member of the active workforce because the cost of health insurance coverage generally increases with the age of the covered individual. However, the cost of providing this insurance through the employer plan is generally less expensive than what the retiree would pay for an individual policy with similar coverage. The coverage provided to early retirees is typically the same as that provided to the employer's active workforce. Some employers provide coverage to early retirees that terminates when the retiree attains age 65.

Nearly all individuals age 65 or older are eligible for Medicare. For these people, the employer-sponsored retiree health benefit acts as a supplement to Medicare. Because retiree health plans treat Medicare as the primary payor for medical expenses and these plans are coordinated with Medicare, the cost of this insurance may be significantly lower than the cost of insurance for active employees and early retirees. The Medicare Catastrophic Coverage Act of 1988 (P.L. 100-360), by expanding the scope of Medicare benefits, will reduce further the cost of employer-sponsored retiree health insurance for the age 65 and over population.

The reported number of retirees and dependents age 65 or older covered by retiree health care plans depends on the methodology and data source. The Department of Labor estimated there were 4.3 million persons covered in 1983 while private estimates ranged as high as 7.6 million persons covered in 1984. Intermediate estimates support the view that nearly 25 percent of the age 65 and over population received, in addition to Medicare, private insurance through an employer-sponsored retiree health plan in 1983. The number and proportion of retirees and dependents of retirees under the age of 65 by retiree health plans is smaller.

The Department of Labor estimated that the total accrued liability (i.e., the net present value of post-retirement health benefits the rights to which both active and retired employees have currently earned) for all employers was $98 billion at the end of 1983.

Employer contributions to fund post-retirement medical benefits and the benefits provided under such plans to retired employees or their dependents are generally excludable from the gross income of such employee or beneficiary.

Under present law, tax-favored prefunding of post-retirement medical benefits can be accomplished in two basic ways: (1) through a tax-qualified pension plan by establishing a separate account under a pension or annuity plan that satisfies certain requirements (sec. 401(h)), or (2) through a welfare benefit fund (secs. 419 and 419(A)). In addition, distributions from qualified pension plans may be used by the plan participant to acquire post-retirement medical benefits, although the pension distribution generally is taxable to the retiree.

Under the separate account method of prefunding post-retirement medical benefits, a tax-qualified pension or annuity plan may provide for the payment of sickness, accident, hospitalization and medical expenses for retired employees, their spouses, and their dependents provided (1) certain additional qualification requirements are met, (2) and the medical benefits, when added to any life insurance protection provided under the plan, are incidental to the retirement benefits provided by the plan.

Under the second tax-favored funding method for retiree health benefits, an employer may establish a welfare benefit fund to provide for post-retirement medical benefits. If such fund satisfies certain requirements, employer contributions to the fund are deductible (within limits). The fund is also tax exempt if it is established as part of a voluntary employees' benefit association (VEBA) (sec. 501(c)(9)) providing for the payment of life, sick, accident, or other benefits to the members of such association or their dependents or designated beneficiaries, if no part of the net earnings of such association inure (other than through such payments) to the benefit of any private shareholder or individual and the VEBA satisfies certain rules prohibiting the provision of benefits on a basis that favors the employer's highly compensated employees (as defined in sec. 414(q)).

Although a VEBA generally is exempt from tax, it is taxable on its unrelated business taxable income (UBTI). Generally, income set aside to provide for post-retirement medical benefits is considered UBTI, although this rules does not apply to a VEBA if substantially all the contributions to the VEBA are made by employers who are exempt from income tax throughout the 5-taxable-year period ending with the taxable year in which the contributions were made.

The welfare benefit fund account limits permit an employer to fund retiree health benefits over the working life of the employee. In addition, benefits for individuals who have already retired may be funded immediately. In other words, the qualified direct costs generally represents the amounts expended during the year for current benefits.

There have been numerous proposals made in the retiree health area that would allow more extensive tax-favored prefunding by employers of post-retirement medical benefits than is allowed under present law. These proposals generally fall into one of five broad categories that are discussed in more detail below: (1) the

VEBA/sec. 401(h) model; (2) the defined health benefit plan; (3) the defined dollar benefit plan; (4) the defined contribution plan; and (5) the qualified retirement plan surplus approach.

II. HEALTH CARE ISSUES RELATING TO POST-RETIREMENT MEDICAL BENEFITS

A. Background

In general

Post-retirement medical benefit plans (i.e., retiree health plans) are plans maintained by employers to pay for all or a portion of the medical costs of retired employees of the employer (and possibly also their dependents) either directly or through insurance plans. Generally, the employer finances all or a significant portion of the cost of this benefit for the retiree. The costs for both the employer and the beneficiary of these retiree health benefits depends greatly on the age of the beneficiary.

For retirees under the age of 65, the employer-sponsored health benefit normally represents the primary source of medical insurance because such retirees generally are not eligible for Medicare benefits. The cost of insuring an early retiree usually exceeds the average cost of insuring a member of the active workforce because the cost of health insurance coverage generally increases with the age of the covered individual. However, the cost of providing this insurance through the employer plan is generally less expensive than what the retiree would pay for an individual policy with similar coverage. The coverage provided to early retirees is typically the same as that provided to the employer's active workforce. Some employers provide coverage to early retirees which terminates when the retiree attains age 65.

Nearly all individuals age 65 or older are eligible for Medicare. For these individuals, the employer-sponsored retiree health benefit acts as a supplement to Medicare. Because retiree health plans treat Medicare as the primary payor for medical expenses and these plans are coordinated with Medicare, the cost of this insurance is often significantly lower than the cost of insurance for active employees or early retirees. The Medicare Catastrophic Coverage Act of 1988 (P.L. 100-360), by expanding the scope of Medicare benefits, will reduce further the cost of employer-sponsored retiree health insurance for the age 65 and over population.[2]

Recently, there has been increasing focus on the value of post-retirement medical benefits that employers have promised their employees, and the issue of funding those benefits. The concern of employers is, in part, a reaction to the stated intent of the Financial Accounting Standards Board ("FASB") to require employers subject to the FASB rules to include the value of unfunded retiree health liabilities as a liability on annual financial statements. Com-

[2] The maintenance of effort provisions in the Act will initially require the employer to pass through to the retiree, some of the savings in the cost of retiree health benefits for two years.

panies may also be concerned, whether or not FASB requires such reporting, about the effect such unfunded liabilities may have on potential investors and creditors.

Currently, many employers do not prefund retiree health benefit liabilities, and the amount of unfunded liabilities may be substantial. Some employers have not funded these benefits because they assumed, based on an interpretation of present law that the benefits could be reduced or eliminated in the future if the cost of the benefits became too high.

Coverage

The reported number of retirees and dependents age 65 or older covered by retiree health care plans depends on the methodology and data source. The Department of Labor estimated there were 4.3 million retirees and dependents age 65 or older covered in 1983 while private estimates range as high as 7.6 million such persons covered in 1984; these correspond to 16 percent and 27 percent of the age 65 and over population, respectively.[3] Intermediate estimates support the view that nearly 25 percent of the age 65 and over population received, in addition to Medicare, private insurance through an employer-sponsored retiree health plan in 1983.[4]

The number and proportion of retirees and dependents of retirees under the age of 65 covered by retiree health plans is smaller. The Department of Labor estimated 2.6 million retirees and dependents under the age of 65 were covered by these plans in 1983. Again, private estimates are higher and claim that the number of persons covered in 1984 was 3.8 million.[5] These estimates correspond to 26 percent and 38 percent of those age 55 through 64 who were not in the labor force, respectively.

Estimates vary considerably on the number of current active employees who may eventually receive retiree health benefits. The Department of Labor estimated for 1983 that over 10 million then active employees age 40 and over (along with their eligible spouses and dependents) would eventually receive retiree health benefits if the plans were not changed. Other private estimates suggest that the number of eligible active employees who may receive benefits could be more than twice as great.[6]

A separate Department of Labor survey shows that 76 percent of full-time employees of medium and large firms participate in employee benefit plans that make them potentially eligible for post-retirement health benefits.[7] However, participation in a benefit plan that includes post-retirement health insurance does not mean these active employees will eventually receive the benefit. Employees generally earn the right to post-retirement health benefits only

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[3] Office of Policy and Research, Pension and Welfare Benefits Administration, United States Department of Labor, "Employer-Sponsored Retiree Health Insurance", May, 1986. Chollet, "Retiree Health Insurance Benefits: Trends and Issues", Employee Benefit Research Institute, forthcoming, 1988.

[4] Short and Monheit, "Employers and Medicare as partners in Financing Health Care for the Elderly", National Center for Health Services Research and Health Care Technology Assessment, December, 1987.

[5] Department of Labor, and Chollet, *supra.*

[6] Dopkeen, "Post-Retirement Health Benefits", *Health Services Research*, Vol. 21, No. 6, 1987.

[7] U.S. Department of Labor, Bureau of Labor Statistics, *Employee Benefits in Medium and Large Firms, 1986*, June 1987.

after a significant period of service with the employer. Typically, the employee must attain a stated retirement age while still employed by the employer. Thus, if an otherwise eligible employee terminates employment before attaining the stated retirement age, the right to post-retirement health benefits will be lost.

At least until recently, the most recent retirees were more likely to receive post-retirement health benefits than were the older employees who retired before them. If this pattern continues, the number and percentage of retirees receiving employer-sponsored health benefits will continue to grow. Some believe that recent concerns by employers about the rising cost of medical insurance, particularly for retirees, may cause the growth in the covered population to slow and possibly even reverse. In addition, the expanded coverage of benefits under Medicare may reduce the actual or perceived need for employer-provided retiree health benefits.

Estimates of retiree health liabilities

The Department of Labor estimated that the total accrued liability (i.e., the net present value of post-retirement health benefits the rights to which both active and retired employees have currently earned) for all employers was $98 billion at the end of 1983. Since most post-retirement health benefits are not prefunded, the accrued liability represents the present value of funds the employer must raise and pay in the future for their currently promised benefits. This amount compares to the Department of Labor estimate for the pay-as-you-go current expense of $3.9 billion in 1983 and $4.6 billion in 1985. It is expected that more current, updated estimates would generate somewhat higher values both for the current cost and accrued liability due to the increase in the number of persons covered and the rapid increase in the costs of medical care.[8] Of course, employers have the ability currently to prefund on a tax-favored basis a portion, but not likely all, of the accrued retiree health liability through the use of VEBAs or other welfare benefit funds.

B. Retiree Health Plans and Health Care Policy

In general

The fundamental tradeoff in health policy is between the desire to provide adequate access to health care while maintaining an acceptable cost structure. Advocates of additional tax preferences for employer-provided post-retirement health benefits suggest that employer-provided coverage provides an efficient means of assuring adequate health insurance coverage to a population which otherwise might have great difficulty in obtaining acceptable levels of health care. Opponents of such tax incentives point out that the benefits of tax preferences (including the current exclusion of em-

[8] Joseph Califano, in testimony before the Joint Economic Committee (Senate Hearing 98–1193) in 1984, was the source for a frequently cited statement that the potential unfunded liability for health coverage could possibily be as high as $2 trillion for the U.S. Fortune 500 companies. It appears that this estimate is based solely on an extrapolation of the experience of one company, Chrysler, to the whole Fortune 500. Given Chrysler's unusual situation, this estimate may be a significant overestimate of the actual aggregate unfunded liability.
The General Accounting Office is currently working on an updated estimate of the liability.

ployer contributions) may be concentrated among those best able to provide for themselves, i.e., higher compensated employees, while imposing additional costs on the health care system.

Costs and methods of providing coverage

For those who retire before age 65 and thus normally are not eligible for Medicare, employer-sponsored retiree health benefits may be the only source of health insurance. Employer-sponsored health insurance may represent a relatively low-cost form of insurance for this population. Most retiree health benefits are provided as part of the employer's group coverage. Employer group coverage usually has lower overhead costs and lower rates than would be available through individually purchased medical insurance. In general, individuals most likely to file health insurance claims are the ones most likely to purchase insurance. Because of this likelihood of adverse selection, individually purchased health insurance policies can be prohibitively expensive or provide only limited coverage.

Some have proposed that the favorable group rates available to employer for health plans could be passed on to individuals through a system similar to the health care continuation coverage required to be provided under present law (sec. 162(k)). The present law health care continuation coverage rules require, in general, that an employer must offer a qualified beneficiary who loses health care coverage under the employer's plan due to a qualifying event (e.g., termination of employment or divorce) the opportunity to elect to receive the same coverage the individual was receiving prior to the qualifying event. The coverage is required to be provided for a temporary period only, generally either 18 or 36 months. The employer can charge the qualified beneficiary for the coverage. However, the charge can be no more than 102 percent of the cost to the plan for coverage of similarly situated active employees.

Making group rates available to retired employees through extended health care continuation coverage could reduce the cost of retiree-paid health insurance when compared to individual policies, although it still may be unaffordable for some individuals. To the extent that the employer pays the cost of the coverage, post-retirement health benefits offered by the employer may make health care more available to the retiree population some of whom otherwise may have been uninsured because they could not afford to pay the cost of the coverage. Continuation coverage could be made mandatory, with or without a requirement that the employer pay a portion of the cost. This would involve issues similar to those arising in connection with currently discussed proposals for mandatory health insurance coverage of active employees.

Retiree health, Medicare, and the demand for medical services

The existing individual income tax preferences for employer-provided health coverage provide an incentive to consume health care relative to goods that are paid for with after-tax dollars. Also, if the individual entitled to health care normally bears only a fraction of the cost of medical services covered by insurance, there is an incentive to spend more on health care than if the individual paid the full price of medical care. This increase in demand for medical services may drive up the cost of medical care for every-

one. Increased subsidies for post-retirement health benefits may serve to increase the number of persons covered by medical insurance but may also serve to raise the overall cost of medical care.

The problem of increased demand for medical care may be most acute in the age 65 and over population which is covered by Medicare. Employer-provided post-retirement health benefits generally provide reimbursement for costs not fully covered by Medicare. With the passage of the Medicare Catastrophic Act of 1988, the quantity of medical services not covered by Medicare will be significantly reduced. This should reduce the cost of retiree health benefits for the Medicare-eligible population as well as their exposure to large medical bills.

Post-retirement health benefits typically act to reduce the effects of the cost-sharing attributes (i.e., copayments and deductibles) of the Medicare program. This reduction in cost sharing may increase the utilization of medical services, and, because Medicare bears the majority of the cost of many medical services, may increase significantly the costs of the Medicare program.[9] However, widespread provision of retiree health insurance may also serve to reduce some costs to the government by reducing the cost to the government as the insurer of last resort (for example, through the Medicaid program). It is likely that some retiree health coverage simply replaces individually-purchased Medigap policies. To the extent that this is true, there may be a relatively small net effect on the cost of the Medicare program.

Although many studies suggest that reduced cost-sharing can significantly increase the utilization of medical services and thus the cost to the government as a primary insurer, some argue that it is important to assist further the aged with their health costs. They argue that, even after the passage of the Medicare Catastrophic Coverage Act, Medicare is insufficient to protect the aged from large and potentially debilitating medical bills. They argue that the Federal government should encourage more private insurance of medical costs.

Others claim that the revised Medicare system generally provides an appropriate balance among the goals of providing access to health care, protection from overwhelming medical bills, and cost containment through cost-sharing provisions. They see further encouragement of post-retirement health benefits as distorting these incentives inappropriately to the advantage of a group least in need of assistance and to the detriment of the remainder of the health care system. Some of these commentators have argued, in contrast, that there should be an excise tax levied on the provision of any insurance policy which supplements Medicare in order to re-

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[9] *See*, for example, C. R. Link, S. Long, and R. Settle, "Cost Sharing, Supplementary Insurance, and Health Services Utiiization Among the Medicare Elderly" *Health Care Financing Review* 2 (Fall 1981); J. P. Newhouse, W. G. Manning, C. N. Morris, *et al*, "Some Interim Results from a Controlled Trial of Cost Sharing in Health Insurance," *New England Journal of Medicine* 305:1501-7 (1981); and W. Hsiao and N. Kelly, "Restructuring Medical Benefits," in *Proceedings of the Conference on the Future of Medicare*, U.S. House of Representatives, Subcommittee on Health of the Committee on Ways and Means, 1984. Link, Long and Settle found that medigap policies increased the utilization of medical services between 30 and 40 percent. Hsiao and Kelley report that the Medicare reimbursements were 35 percent higher for individuals with medigap coverage in 1080 than those with only medicare coverage. This cost difference, however, may not be due solely to the effect of medigap policies

flect properly the increased Federal Medicare outlays which may be caused by the provision of this insurance.

C. Labor Force Participation

In 1955, the labor force participation rate of men aged 65 or more was 39.6 percent. In 1986, the labor force participation rate of men aged 65 or more had fallen to 16.0 percent. Over the same period, the labor force participation rate of men aged between 55 and 64 fell from 87.9 to 67.3 percent.[10] While many factors, such as health and family needs influence an individual's decision to seek employment or remain employed, many believe that the growth of social security benefits and private pensions has had a substantial effect on the retirement and labor force participation decision.[11]

If this analysis is accurate, additional tax preferences for retiree health benefits could affect labor force participation rates. New tax incentives providing for funding of post-retirement health benefits could induce a shift in employee compensation towards more post-retirement compensation. The value of post-retirement health benefits would be greatest for those younger employees who are not yet Medicare eligible. Growth in post-retirement benefits could make retirement and the accompanying leisure time a more attractive option, thereby inducing earlier retirements.

The existence of post-retiree health benefits could make it less attractive for some retirees to re-enter the labor force on either a full or part-time basis. Presently, retirees who are not covered by employment-related plans may choose to work in order to gain health coverage through an employer or to gain extra income to directly purchase medical insurance. Incentives leading to the expansion of employer-provided post-retirement health care could reduce these reasons for older Americans to remain in the labor force. In addition, for one who was covered by a post-retirement health plan, working for an employer who provides compensation in the form of health benefits could become less attractive because the benefits would be largely redundant.

Reductions in labor force participation by the elderly could lead to a loss of skilled workers and production to the economy. In addition, reduced employment could lead to a loss of revenue from both income and social security taxes.

D. Minimum Standards

The minimum standards applicable to pension plans are imposed in order to ensure that such plans accomplish the purposes for which they are provided such significant tax benefits, that is, the provision of retirement benefits to rank-and-file employees. For the

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[10] U.S. Department of Labor, *Employment and Training Report of the President*, 1982. U.S. Department of Commerce, *Statistical Abstract of the United States 1988*.

[11] *See*, Michael J. Boskin and Michael D. Hurd, "The Effect of Social Security on Early Retirement," *Journal of Public Economics*, 10, 1978, and Gary Burtless and Robert A. Moffitt, "The Effect of Social Security Benefits on the Labor Supply of the Aged," in Henry J. Aaron and Gary Burtless, editors, *Retirement and Economic Behavior*, (Washington: Brookings, 1984). Boskin and Hurd estimate that an increase in social security benefits of $1,000 per year would increase the likelihood of retirement of any male employee aged 60 or greater by 8 percent. Burtless and Moffitt estimate that for those 64 year old males who retired from their primary job, yet continue to work, that an increase in the social security benefit of $500 per year would reduce their labor supply by 1.62 hours per week.

same reasons that minimum standards apply to pension plans, some argue that additional tax benefits should not be provided to retiree health plans unless additional minimum standards, such as vesting and accrual rules, apply.

Those who oppose the idea of conditioning tax-favored funding of retiree benefits on the imposition of additional minimum standards typically use the same arguments that have been used in the pension area. They argue that minimum standards reduce the flexibility of employers in creating compensation packages and responding to the particular needs of their employees, and will discourage employers from adopting new plans or cause employers to terminate existing plans. In addition, it is significantly more difficult to determine how minimum standards apply in the case of retiree health benefits because the benefits generally are not a set dollar amount. Considerable difficulty would apply in establishing vesting and accrual rules for retiree health benefits.

At present, employer-provided post-retirement health benefits are more often a benefit of higher income employees than of lower income employees. As Table 1 indicates, in 1983 while over 30 percent of middle- and high-income elderly benefited from employer-provided retiree health insurance, less than 10 percent of the poor and near poor received similar benefits. Consequently, the benefits from pre-funding existing plans may flow more to higher income retirees than to lower income retirees. Also, to the extent that different employers and plans provide differing levels of benefits or no benefits at all, some employers and employees would benefit more than others.

Table 1.—Private Health Insurance of the Medicare Elderly, 1983

All Medicare elderly	Number of persons (thousands)	Percent no private insurance	Percent other private insurance	Percent employment related insurance	Sources of employment-related private insurance (percentages of total)			
					Active worker	Dependent of active worker	Retiree	Dependent of retiree
Total	25,329	29.2	39.6	31.1	3.7	2.8	18.4	6.2
Family income,[1] adjusted for family size:								
Poor	3,080	65.6	29.7	4.7	0.8	0.1	3.7	0.1
Near Poor	2,358	49.8	41.3	8.9	0.8	0.4	6.7	0.9
Low	5,621	32.2	48.0	19.8	1.0	0.6	15.3	2.9
Middle	9,504	18.1	39.9	41.7	4.0	3.1	24.9	9.7
High	4,765	14.2	34.8	51.0	9.6	7.7	24.3	9.4

[1] Poor denotes households with income less than the poverty level; Near Poor, between 100 and 150 percent of the poverty level; Low, between 150 and 200 percent of the poverty level; Middle, between 200 and 400 percent of the poverty level; High, household incomes in excess of 400 percent of the poverty level.

Source: National Center for Health Services Research and Health Care Technology Assessment, U.S. Department of Health and Human Services.

III. PRESENT LAW

A. In General

Post-retirement medical benefit plans (i.e., retiree health plans) are plans maintained by employers to pay for all or a portion of the medical costs of retired or former employees of the employer (and possibly also their dependents) either directly or by the purchase of insurance. Generally, the employer finances all or a significant portion of the cost of this benefit for the retiree. The costs for both the employer and the beneficiary of these retiree health benefits depends greatly on the age of the beneficiary.

Under present law, post-retirement medical benefits are generally excludable from the gross income of a plan participant or beneficiary. Present law provides two tax-favored funding arrangements to accumulate assets to provide post-retirement medical benefits separately from other retirement benefits. First, separate accounts in certain qualified retirement plans may be used to provide post-retirement medical benefits (Code sec. 401(h)).

Although assets allocated to a post-retirement medical benefit account are accorded tax treatment similar to that provided for other assets held by a qualified retirement plan, the benefits provided under post-retirement medical accounts are required to be incidental to the retirement benefits provided by the plan. The incidental benefit requirement may preclude funding the entire post-retirement medical benefit through a separate account in a qualified plan.

The second funding medium that can be used to prefund post-retirement medical benefits is a welfare benefit fund (secs. 419 and 419A). Welfare benefit funds generally are not subject to the contribution limits applicable to the separate accounts under a qualified plan, but are subject to separate limits on the deductibility of employer contributions. In addition, medical benefits provided through a welfare benefit fund are excluded from the employee's gross income unless the benefits are provided on a discriminatory basis. However, income set aside in a welfare benefit fund to provide post-retirement medical benefits generally is subject to income tax.

Although advance funding of post-retirement medical benefits is not accorded tax treatment comparable to that provided for retirement benefits under qualified retirement plans, they also are not subject to the same minimum standards applicable to retirement plans.

In addition to the two methods described above for funding post-retirement medical benefits, plan participants may, of course, use distributions from qualified plans to purchase post-retirement medical benefits. The use of such retirement plan distributions to pur-

chase post-retirement medical benefits is equivalent to the purchase of such benefits on an after-tax basis from other income.

B. Employee Tax Treatment of Post-Retirement Medical Benefits

The value of employer-provided coverage under a health plan that provides post-retirement medical benefits to former employees, their spouses, or dependents is generally excludable from gross income (sec. 106). The exclusion applies whether the coverage is provided by insurance or otherwise. Thus, for example, the exclusion applies if the employer pays insurance premiums for post-retirement medical coverage, or provides post-retirement medical benefits through a trust.

Gross income generally does not include amounts that are paid directly or indirectly to a former employee to reimburse him or her for expenses incurred for the medical care of the former employee or his or her spouse or dependents. The exclusion applies whether the benefits are paid for by employer contributions (sec. 105) or employee contributions (sec. 104).

For years prior to 1989, the exclusion for medical care reimbursements does not apply to amounts paid to a highly compensated individual under a self-insured medical reimbursement plan unless certain nondiscrimination requirements are satisfied (sec. 105(h)). In general, a self-insured medical reimbursement plan is considered discriminatory under these rules if it favors highly compensated individuals either as to eligibility to participate or as to benefits.

The Tax Reform Act of 1986 added specific nondiscrimination rules that apply to the value of the employer-provided coverage under all health plans, generally effective for years beginning after 1988 (sec. 89). If a health plan does not satisfy these nondiscrimination rules, then the highly compensated employees or highly compensated former employees participating in the plan are required to include in gross income the excess benefit received under the plan. The excess benefit is, in general, the excess of the value of the employer-provided benefit over the maximum employer-provided benefit that could be provided if the plan were nondiscriminatory. For this purpose, the employer-provided benefit is the value of the health coverage provided by the employer (not the amount of reimbursements received under the plan).

In addition, generally for years beginning after 1988, gross income includes an employee's or former employee's total employer-provided benefit unless the plan meets certain qualification requirements (sec. 89(k)), such as for example, a requirement that the plan be in writing, and that the employee's rights under the plan are legally enforceable. For this purpose, the employer-provided benefit is the amount of reimbursements received, rather than the value of the coverage (e.g., the insurance premiums).

C. Employer Tax Treatment of Contributions for Post-Retirement Medical Benefits

Current benefits

Post-retirement medical benefits that are not funded through a qualified retirement plan or a welfare benefit fund are generally

treated for employer deduction purposes the same as deferred compensation that is provided under a nonqualified deferred compensation plan (sec. 404). Nonqualified deferred compensation is deductible by the employer for the taxable year in which the compensation is includible in the income of the employee, or would be includible in the gross income of the employee without regard to any exclusion. Thus, employer contributions to provide post-retirement medical benefits are deductible when the coverage is provided to the former employee.

The deduction rules for post-retirement medical benefits provided through a qualified plan or a welfare benefit fund are discussed below.

Prefunding of future benefits

In general

Under present law, tax-favored prefunding of post-retirement medical benefits can be accomplished in two basic ways: (1) through a tax-qualified pension plan by establishing a separate account under a pension or annuity plan that satisfies certain requirements (sec. 401(h)), or (2) through a welfare benefit fund (secs. 419 and 419(A)). In addition, distributions from qualified plans may be used by the plan participant to acquire post-retirement medical benefits.

Separate account under qualified pension plans

Under the separate account method of prefunding post-retirement medical benefits, a tax-qualified pension or annuity plan may provide for the payment of sickness, accident, hospitalization and medical expenses for retired employees, their spouses, and their dependents provided certain additional qualification requirements are met with respect to the post-retirement medical benefits (sec. 401(h)). First, the medical benefits, when added to any life insurance protection provided under the plan, are required to be incidental to the retirement benefits provided by the plan. The medical benefits are considered incidental or subordinate to the retirement benefits if, at all times, the aggregate of employer contributions (made after the date on which the plan first includes such medical benefits) to provide such medical benefits and any life insurance protection does not exceed 25 percent of the aggregate contributions made after such date, other than contributions to fund past service credits. Additional medical benefits and life insurance protection may be provided with employee contributions.

The second requirement is that a separate account is to be maintained with respect to contributions to fund such medical benefits. This separate accounting generally is determined on an aggregate, rather than a per-participant basis, and is solely for recordkeeping purposes.

The rationale for requiring that the post-retirement medical benefits funded in this manner be subordinate and be provided under a separate account is that such benefits generally are not subject to the minimum standards, such as vesting, funding, and accrual rules, generally applicable to qualified retirement plans. In addition, such benefits are not subject to any Federal guaranty, such as the guaranty provided by the Pension Benefit Guaranty Corpora-

tion with respect to pension benefits. Thus, Congress considered it important not only to limit the tax-favored treatment of such benefits but also to ensure that these relatively unrestricted benefits did not reduce the funds contributed to provide nonmedical retirement benefits pursuant to the minimum standards.

The third requirement is that the employer's contributions to a separate account are to be reasonable and ascertainable. Fourth, the plan is required to preclude the use of amounts in the separate account for any other purposes at any time prior to the satisfaction of all liabilities with respect to the post-retirement medical benefits. Fifth, upon the satisfaction of all plan liabilities to provide post-retirement medical benefits, the remaining assets in the separate account are to revert to the employer and cannot be distributed to the retired employees. Similarly, if an individual's right to medical benefits is forfeited, the forfeiture is to be applied to reduce the employer's future contributions for post-retirement medical benefits.

The final requirement is that, in the case of an employee who is a "key employee" (as defined in sec. 416), a separate account is to be established and maintained on a per-participant basis, and benefits provided to such employee (and his or her spouse and dependents) are to be payable only from the separate account. This requirement applies only to benefits attributable to plan years beginning after March 31, 1984, for which the employee is a key employee. Also, contributions to the separate account are considered annual additions to a defined contribution plan for purposes of the limits on contributions and benefits applicable to retirement plans (sec. 415), except that the 25 percent of compensation limit (sec. 415(c)(1)(B)) does not apply.

If the requirements with respect to post-retirement medical benefits are met, the income earned in the separate account is not taxable. Also, employer contributions to fund these benefits are deductible under the general rules relating to the timing of deductions for contributions to qualified retirement plans. The deduction for such contributions is not taken into account in determining the amount deductible with respect to contributions for retirement benefits. The amount deductible may not exceed the total cost of providing the medical benefits, determined in accordance with any generally accepted actuarial method that is reasonable in view of the provisions and coverage of the plan and any other relevant considerations. In addition, the amount deductible for any taxable year may not exceed the greater of (1) an amount determined by allocating the remaining unfunded costs as a level amount or a level percentage of compensation over the remaining future service of each employee, or (2) 10 percent of the cost that would be required to fund or purchase such medical benefits completely. Certain contributions in excess of the deductible limit may be carried over and deducted in succeeding taxable years.

Welfare benefit funds

An employer may establish a welfare benefit fund to provide for post-retirement medical benefits. A welfare benefit fund is, in general, any fund which is part of a plan of an employer, and through

which the employer provides welfare benefits to employees or their beneficiaries.

If a welfare benefit fund satisfies certain requirements, it generally will be exempt from income tax. In general, to be tax-exempt, the fund is required to be a voluntary employees' beneficiary association (VEBA) (sec. 501(c)(9)) providing for the payment of life, sick, accident, or other benefits to the members of such association or their dependents or designated beneficiaries, and no part of the net earnings of such association may inure (other than through such payments) to the benefit of any private shareholder or individual. In addition, the VEBA generally is required to satisfy certain rules prohibiting the provision of benefits on a basis that favors the employer's highly compensated employees (as defined in sec. 414(q)).

Although a VEBA generally is exempt from tax, it is taxable on its unrelated business taxable income (UBTI). Income set aside to provide for post-retirement medical benefits is considered UBTI, although this rule does not apply to a VEBA if substantially all of the contributions to it were made by employers who are exempt from income tax throughout the 5-taxable-year period ending with the taxable year in which the contributions were made.

Certain special rules apply to the deductibility of employer contributions to a welfare benefit fund without regard to whether the fund is a VEBA. Under these rules, contributions by an employer to such a fund are not deductible under the usual income tax rules (sec. 162), but if they otherwise would be deductible under the usual rules, the contributions will be deductible within limits for the taxable year in which such contributions are made to the fund.

The amount of the deduction otherwise allowable to an employer for a contribution to a welfare benefit fund for any taxable year may not exceed the qualified cost of the fund for the year. The qualified cost of a welfare benefit fund for a year is the sum of (1) the qualified direct cost of the fund for the year and (2) the addition (within limits) to the qualified asset account under the fund for the year, reduced by (3) the after-tax income of the fund.

In general, the qualified direct cost of a fund is the aggregate amount expended (including administrative expenses) that would have been allowable as a deduction to the employer with respect to the benefits provided, assuming the benefits were provided directly by the employer and the employer was using the cash receipts and disbursements method of accounting. In other words, the qualified direct cost generally represents the amounts expended during the year for current benefits.

A qualified asset account under a welfare benefit fund is an account consisting of assets set aside to provide for the payment of disability payments, medical benefits, supplemental unemployment compensation benefits or severance pay benefits, or life insurance benefits. Under present law, an account limit is provided for the amount in a qualified asset account for any year.

The account limit with respect to medical benefits for any taxable year may include a reserve to provide certain post-retirement medical benefits. This limit allows amounts reasonably necessary to accumulate reserves under a welfare benefit plan so that funding of post-retirement medical benefits with respect to an employee

can be completed upon the employee's retirement. These amounts may be accumulated no more rapidly than on a level basis over the working life of an employee with the employer of that employee. Funding is considered level if it is determined under an acceptable funding method so that future post-retirement medical benefits and administrative costs will be allocated ratably to future preretirement years. In addition, benefits for individuals who have already retired may be immediately funded.

Each year's computation of contributions with respect to post-retirement medical benefits is to be made under the assumption that the medical benefits provided to future retirees will have the same cost as medical benefits currently provided to retirees. Because the reserve is computed on the basis of the current year's medical costs, neither future inflation nor future changes in the level of utilization may be taken into account until they occur.

The Deficit Reduction Act of 1984 (DEFRA), which added the deduction limitations for contributions to welfare benefit funds, directed the Secretary of the Treasury to study the possible means of providing minimum standards for employee participation, vesting, accrual, and funding under welfare benefit plans for current and retired employees. The study is to include a review of whether the funding of welfare benefits is adequate, inadequate, or excessive. The Secretary was required to report to the Congress with respect to the study by February 1, 1985, with suggestions for minimum standards where appropriate. The Tax Reform Act extended the due date for the study to October 22, 1987. This study has not yet been completed.

Qualified plan distributions

An individual may use some or all of a distribution from a qualified plan to acquire post-retirement medical benefits. Such amounts would be taxable to the individual under the rules applicable to distributions from qualified plans. Qualified plans thus provide an additional, indirect means of funding post-retirement medical benefits on an after-tax basis.

D. Minimum Standards

Under present law, minimum standards of the type applicable to tax-qualified pension plans generally do not apply to post-retirement medical benefit plans. The Internal Revenue Code contains provisions applicable to tax-qualified retirement plans designed to prohibit discrimination in favor of highly compensated employees, and to ensure that rank-and-file employees, as well as highly compensated employees, actually benefit under the plan. In addition, under both the Code and the Employee Retirement Income Security Act (ERISA), qualified retirement plans are required to meet minimum standards relating to participation requirements (the maximum age and service requirements that may be imposed as a condition of participation in the plan), vesting (the time at which an employee's benefit becomes nonforfeitable), and benefit accrual (the rate at which an employee earns a benefit).

Also, minimum funding standards apply to the rate at which employer contributions are required to be made to ensure the solvency

of pension plans. In general, the benefits provided by defined benefit pension plans are guaranteed by the Pension Benefit Guaranty Corporation (PBGC) in order to prevent loss of benefits in the event an employer terminates a plan while it is in financial distress and has not adequately funded pension benefits.

Except for certain nondiscrimination and basic qualification rules, such minimum standards and requirements do not apply to post-retirement medical benefit plans. As mentioned above, self-funded medical reimbursement plans are currently subject to nondiscrimination rules, and all health plans will generally be subject to nondiscrimination and basic qualification rules beginning in 1989.

Because post-retirement medical benefits are not subject to the same minimum standards applicable to qualified retirement plans, employees' rights to such benefits depend on the particular contractual arrangement between the employees and their employer. The binding nature of such arrangements, as they relate to post-retirement medical benefits, has been the subject of recent litigation. Case law has focused on the right of the employer to terminate post-retirement medical benefits with respect to current retirees. In general, the courts have affirmed an employer's right to terminate a retiree health plan if such right has been unambiguously reserved and clearly communicated to employees. However, the courts have been strict in applying these standards, looking not just at plan documents but also to oral representations. In cases, for example, in which representatives of the employer have told retirees that their benefits would continue for the remainer of their lives, courts have held that the employer could not terminate the retiree health benefits after the employee had retired.

E. Fiduciary Rules

ERISA contains rules governing the conduct of fiduciaries of employee benefit plans. These rules generally apply to all employee benefit plans subject to ERISA, including both employee benefit pension plans and welfare benefit plans. Thus, these rules apply to post-retirement medical benefit plans. ERISA has general rules relating to the standard of conduct of plan fiduciaries, and also specific rules prohibiting certain transactions between a plan and parties in interest with respect to a plan, such as a plan fiduciary.

The general fiduciary standard under ERISA requires that a plan fiduciary discharge his or her duties with respect to a plan (1) solely in the interest of the plan participants and beneficiaries, (2) for the exclusive purpose of providing benefits to participants and their beneficiaries and defraying reasonable administrative expenses of the plan, (3) with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent person acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims, and (4) in accordance with the documents and instruments governing the plan to the extent such documents and instruments are consistent with ERISA.

F. Reporting and Disclosure

ERISA contains reporting and disclosure rules that apply to all employee benefit plans, including post-retirement medical benefit plans. These rules generally require that a plan be in writing, and that certain information with respect to a plan be provided to plan participants and to the Department of Labor. Annual reports on welfare benefit plans are also required to be filed with the Internal Revenue Service.

IV. ANALYSIS OF TAX INCENTIVES FOR PREFUNDING RETIREE HEALTH LIABILITIES

There have been numerous proposals made in the retiree health area that would allow more extensive tax-favored prefunding by employers of post-retirement medical benefits than is allowed under present law. These proposals generally fall into one of five broad categories that are discussed in more detail below: (1) the VEBA/sec. 401(h) model; (2) the defined health benefit plan; (3) the defined dollar benefit plan; (4) the defined contribution plan; and (5) the qualified retirement plan surplus approach. A key issue in funding post-retirement medical benefits is defining what the benefit is. Each of the first four categories of proposals defines the benefit in different ways. (The fifth funding approach could be used to fund any type of benefit.)

The proposals embody several different specific approaches to pre-funding post-retirement health benefits. More generally, there are several approaches which could be taken to address the issue: maintain the present-law tax incentives for prefunding retiree health benefits; create new tax incentives specifically designed to encourage employers to prefund their liabilities; create new specificc tax incentives that mandate that employees prefund their liabilities; or mandate the advance funding of liabilities with no change in tax treatment.

A. Present Law

The Financial Accounting Standards Board (FASB) proposals to require reporting of retiree health liabilities for financial statement purposes, when issued, could induce the private market to prefund such liabilities to avoid any adverse effect on an employer's balance sheet. Some believe that the new liability which FASB may require companies to report will have negative effects on the solvency or perceived solvency of the employers with significant unfunded liabilities. Corporate financing may be harder to obtain for employers reporting large unfunded liabilities for retiree health benefits and, thus, the accounting change may provide an incentive to reduce these liabilities by prefunding.

Absent changes in the tax law or ERISA, employers would retain flexibility in determining how to best provide funds for the employer's retiree health liability.

Market induced prefunding, while solving financial statement problems, may not improve the security of benefits for employees or retirees because employers may not set aside assets solely for the benefit of employees. For example, amounts set aside for retiree health benefits may not be protected from an employer's creditors in the event of bankruptcy.

If the capital markets do react negatively to employers with large unfunded liabilities, in lieu of prefunding its liabilities, an employer may attempt to limit or terminate existing plans. To the extent that this reduction or termination is prohibited by the courts, employers might limit promises of benefits to new employees. Such a result could undermine a goal of improving retiree access to health care.

Some argue that the FASB accounting change alone will not alter the economic circumstances of the employer, so that the accounting change will have little economic impact on the employer beyond providing more accurate information to shareholders. These people believe that investors already consider potential liabilities of the employer to pay retiree health benefits, and that any decision to fund, expand, or curtail retiree health benefits will be made irrespective of a change in accounting rules.

Health benefits for retirees could also be provided through an expansion of an employer's pension plans. With the increased benefits, the retiree could choose to allocate his or her retirement funds between health care and other expenses as he or she deems best. From the employer's perspective, this option is generally equivalent to all proposals which seek to create a specific tax preference for retiree health benefits, except that the monies promised are not dedicated to health care and the amounts that the employer can prefund are determined by reference to the funding and deduction rules for pension plans, rather than by reference to projected or accrued retiree health liability. This approach could be utilized under present law only by those companies which do not make the maximum permissible pension contributions. Some would argue that full use of the present-law pension funding limits indicates that sufficient tax expenditures have been made to induce employers to assist employees in planning for their retirement income and health care needs.

This approach allows the retiree complete flexibility in providing for his or her needs. Being solely responsible for his or her health care needs gives the retiree an incentive to economize on health care costs. This could reduce some of the pressure on health care costs discussed below.

On the other hand, some might argue that retirees may not allocate sufficient amounts of retirement income to health care and that the Federal government should mandate or encourage benefit programs that insure at least some minimum level of health care. In addition, as with any plan which only provides dollars and not services, the risk of increases in health care costs is borne solely by the retiree.

B. Tax Preferences For Prefunding

Accelerating the deductibility of employer contributions for retiree health benefits accelerates the revenue loss to the government. Permitting tax-free earnings on the funds increases the revenue loss to the government. In addition, while pension payments to retirees constitute taxable income, an employer's purchase of health insurance for employees or retirees generally does not, further increasing the revenue loss to the government.

Such tax preferences create subsidies for the limited number of employers who offer post-retirement benefits. This may induce more employers to establish such plans. The earlier funding of such benefits could increase national saving. Nevertheless, as long as the plans are not uniform the tax subsidy would be distributed unequally across all employers and employees.

Some would argue that it is not necessary to create additional tax advantages for funding retiree health benefits, particularly given the fact that very few employers have yet taken advantage of the existing tax-favored means of prefunding (such as the separate account (sec. 401(h)) under a qualified pension plan). The DEFRA limitations on deductions for contributions to welfare benefit funds (discussed above) were enacted as a result of Congressional concern that the prior-law rules, which permitted employers greater flexibility in prefunding, allowed excessive tax-free accumulation of funds. Many of the current proposals for expanding the tax benefits of funding retiree health benefits would reinstate in some form to the pre-DEFRA rules.

Congressional concern about the pre-DEFRA rules was caused by discussions among tax practitioners as to the tax-shelter potential of welfare benefit plans, such as retiree health plans. Commentators had pointed out that the combination of advance deductions for contributions and the availability of tax-exemption for certain employee benefit organizations (such as VEBAs) provided tax treatment very similar to that provided to qualified retirement plans, but with far fewer restrictions. This discussion became considerably more active after Congress, concerned that qualified retirement plans were being used to provide excessive amounts of tax benefits to relatively high income individuals, lowered the limits on annual contributions that could be made to qualified retirement plans and the benefits that could be paid out of them. Some articles recommended the use of VEBAs to recoup deductions lost in qualified pension plans after the lowering of the contribution and benefit limitations. Congress was concerned that substantial advance funding of welfare benefits could ultimately have led to an unacceptable tax burden for many taxpayers who do not participate in these programs.

Accordingly, Congress provided that, as a general matter, employers should not be permitted a current deduction for welfare benefits that may be provided in the future (i.e., for liabilities that are not accrued). This treatment is consistent with income tax rules in other areas, which generally match the time a payor deducts a payment and the time the payee includes the amount in income.

Congress also, however, found that it was appropriate to permit a reasonable level of reserves for the funding of post-retirement medical benefits, and permitted employers to take deductions contributions to fund for such benefits over the active life of the employee. Some would argue that any expansion of the tax benefits for funding retiree health benefits would simply recreate that tax shelter possibilities that existed before the DEFRA limitations.

Some who favor increased incentives to fund retiree health benefits are concerned that smaller employers in particular tend not to offer post-retirement medical benefit plans. One study found that,

while 86 percent of companies that have 1,000 or more employees offer post-retirement health benefits, less than 50 percent of companies with between 50 and 500 employees offer post-retirement health benefits.[12] The most immediate beneficiaries of tax preferences for pre-funding retiree health care would be large employers and their employees. Some assert that the administrative costs per employee of employee benefit programs are lower for large employers than small employers. A tax preference for post-retirement health benefits could offset some of the higher per-employee administrative cost and lead to increased coverage among all employers. However, because large employers already offer such benefits, they would tend to gain the most from any tax preference that is equally available to all employers.

C. Mandatory vs Optional Prefunding

Tax-favored prefunding of post-retirement medical benefits could be mandatory or permissive. That is, an employer that has a post-retirement medical benefit plan could be required to prefund the benefits in accordance with specific statutory rules or could be permitted, but not required, to prefund such benefits.

Optional funding has the advantage that it provides an employer with flexibility in meeting its benefit obligations. However, optional funding may result in inadequate funding of retiree health benefits if other incentives to prefund are insufficient. Because very few employers have taken advantage of existing tax benefits for retiree health benefits, employers may not be willing to fund these benefits without mandatory funding rules. On the other hand, some would argue that the present-law tax incentives for prefunding retiree health liabilities generally are inadequate to induce employers to prefund such liabilities.

Because the present-law rules for funding post-retirement health benefits are optional, some would argue that retiree health benefits are now similar to pension benefits prior to ERISA when employers generally were not required to set aside sufficient funds to pay promised benefits.

Mandating the funding of retiree medical benefits ensures that sufficient funds will be available to provide the promised benefit. On the other hand, some employers may not be willing to accept a new funding obligation. Mandatory funding could discourage employers from establishing retiree health benefit plans in the future or, if the employer already has such a plan, cause the employer to reduce benefits or terminate the plan. (Such effects could also occur if the reaction of financial markets causes employers to fund retiree health benefits.) Mandated pre-funding could also increase the short-term labor costs for some employers, placing them at a competitive disadvantage to both domestic and foreign rivals that do not have such obligations.

D. VEBA/Sec. 401(h) Model

As is the case with the following three categories of proposals, the VEBA/sec. 401(h) model would allow more extensive tax-fa-

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[12] Dopkeen, *supra.*

vored prefunding of retiree health benefits by increasing the amount that an employer may contribute to a trust on a deductible basis and/or by increasing the extent to which the income of the trust is exempt from tax. The distinctive element of the VEBA/sec. 401(h) model is that no individual employee would, under the proposals, acquire any right to benefits from the trust. This model does include an incentive for employers to use the trust assets to provide retiree health benefits. Generally, such incentive takes the form of an excise tax applicable to assets diverted to other purposes. However, the additional tax-favored prefunding would be permitted even if an employer retained the right to eliminate all benefits with respect to any individual employee.

The advantage of the VEBA/sec. 401(h) model is the flexibility it provides to employers who can retain the right to change the plan in any way they see fit. One disadvantage of the VEBA/sec. 401(h) model is that it allows the employer to confer tax-favored retiree health benefits on a narrow, select group (such as those who qualify for benefits under the plan). Another disadvantage of this model is that it does not provide any benefit security to any employee, thus denying employees the ability to plan efficiently for their retirement.

An example of the basic VEBA/sec. 401(h) model is H.R. 1660, introduced by Mr. Rowland on March 17, 1987.

Other proposals use a variation of the VEBA/sec. 401(h) model under which the use of corporate owned life insurance (COLI) to fund retiree health benefits is facilitated. The key difference between the COLI variation and the basic VEBA/sec. 401(h) model is that the COLI variation generally does not include a trust. Thus, the employer enjoys current access to the assets, which provides further flexibility for the employer with a concomitant reduction in employees' benefit security.

An example of the COLI variation is H.R. 3778, introduced by Mr. Daub on December 17, 1987. (Although it has not been proposed, there is no theoretical reason preventing the use of COLI in connection with the next three prefunding models; the COLI concept is simply a means of obtaining tax benefits.)

E. Defined Health Benefit Plan

Like the VEBA/sec. 401(h) model, the defined health benefit plan allows more extensive tax-favored prefunding of retiree health benefits. However, unlike the VEBA/sec. 401(h) model, one condition of this more extensive tax-favored prefunding is that individual employees earn rights to benefits under the trust that the employer may not eliminate or modify.

In general, the defined health benefit plan establishes a particular health plan that is the plan benefit. Such a health plan could be described by reference to the plan that is (or was) provided to active employees. An individual employee's right to coverage under this plan during his or her retirement is earned by virtue of the employee satisfying certain service requirements. The statute could limit the length of service an employer could require for coverage under the plan to, for example, 10 years.

The advantages of the defined health benefit plan are the benefit security it provides to the employees and, depending on the length of the service requirement, the breadth of the class of employees benefitting under the plan. Vesting requirements for post-retirement health benefits with a service vesting requirement could induce employees to remain with one employer longer than they otherwise would. This could benefit the employer by making it easier to retain trained employees. On the other hand, labor market mobility could be reduced, making workers slower to respond to new employment opportunities.

There are several disadvantages with this type of approach. First, it is difficult to determine what an appropriate level of funding is, because it is difficult to determine what the benefit will be. Increases in the cost of health care are not easily predictable, thus making it difficult to estimate what the benefit will be worth by the time the employee retires. In addition, changes in health care technology and provider methods may occur, thus altering the benefit promise, and making predictions about the appropriate funding levels inaccurate. These difficulties could exacerbate overfunding and underfunding problems, discussed below. In addition, the employer bears significant risks with respect to increases in the cost of health care with respect to the benefits promised. Further, there are underfunding and overfunding problems. With respect to the former, the Federal Government would be required to address the problem of employers and the trusts they create not having sufficient assets to pay the promised benefits. Some commentators have raised the possibility of creating a Federal guarantor for this purpose, similar to the Pension Benefit Guaranty Corporation (PBGC), which ensures retirement benefits under defined benefit pension plans. Proponents of a Federal guarantor argue that a guaranty is necessary to ensure that individuals actually receive their benefits. However, the PBGC is currently operating with a deficit, and recent legislation (the Pension Protection Act of 1987) was necessary to address the financial problems of the PBGC. Such financial difficulties could also arise with respect to a Federal guarantor of post-retirement medical benefits. Indeed, such a guarantor could be required to pay benefits in more situations than the PBGC because of the difficulty of estimating future health care costs.

With respect to overfunding, the problems that have arisen with respect to qualified retirement plans would arise. Appropriate limitations would be necessary so that employers may not use the post-retirement medical plan as a tax-favored bank account. Thus, limitations on the amounts that are deductible would be necessary. In addition, the problem of what to do with any excess assets, (e.g., do they belong to the employer, or does some or all of any excess belong to the employees) which is currently an issue in the pension area, would need to be addressed.

If an individual employee's benefit is expressed in terms of a health plan, rather than a dollar amount, certain administrative problems arise. For example, it is difficult to have employees earn rights in a health plan gradually over time. Some sort of cliff vesting and accrual of employee's rights thus may be necessary. Also, this type of arrangement makes it difficult for employees to accu-

mulate benefits earned from different employers without inefficient duplication of benefits.

An additional acturial difficulty exists in determining the extent of the future liability incurred by such a plan. It is a more difficult task to account for price changes in a specific sector than for overall costs. For example, a pension fund can invest in assets such as corporate securities or real estate which typically appreciate as the overall cost of living increases, and thereby insure their promise to provide a prespecified, inflation-adjusted income level. Such a strategy would not be as effective for provision of health services, the price of which has been rising and may continue to rise substantially faster than the overall price level. The task can be complicated as the health needs of the elderly change over time.

As with pension plans, employers typically impose a service requirement before the retiree health benefit is vested in the employee. Becasue retiree health plans specify service levels rather than dollar levels, problems can arise with vesting policies. While complete vesting for pension beneifts typically means different retires receive different retirement incomes based upon their years of service and income, complete vesting for retiree health benefits usually implies full coverage in a group health insurance plan. Unlike pension plans, to be vested most retiree health plans require the employee to have been employed immediately before his or her retirement. Consequently, portability of retiree health benefits is more limited than portability of pension benefits. Estimating the funds required for prefunding, therefore, depends upon estimates of the number of employees who will remain with the firm until retirement.

Altering vesting requirements to more closely parallel those for pension plans creates other potential problems. If, for example, fifteen years of service were required for complete vesting in any employer's plan, it would easily be possible for one retiree to be completely vested in two or more different health insurance plans. This could create problems of coordination of multiple health insurance policies held by the retiree, and further complicate the calculation of the employer's future liability. Similarly, the concept of partial vesting is difficult to implement when the benefit is measured in units of service rather than measured in dollars.

A substantial advantage to the retiree of a defined health service benefit plan is that the risk of cost increases for health care is substantially borne by the employer. As health care costs rise, subject to the employer's co-insurance rate, the increases in cost are borne by the employer because of the promise to provide specified medical services.

F. Defined Dollar Benefit Plan

The defined dollar benefit plan is similar to the defined health benefit plan except that the benefit is expressed not in terms of a specific health plan, but in terms of an annual dollar benefit. This dollar benefit would be available to provide health benefits to employees in their retirement. The amount could be paid directly to an insurance company for coverage of employees, could be used by the employer to fund its own self-insured plan, or could be paid to

the employee to reimburse him or her for the cost of purchasing health insurance or for the cost of medical expenses incurred.

The advantages of this type of plan are based on the fact that it is expressed in terms of a dollar amount, rather than a particular health plan. This makes the employers' costs more predictable and controllable. Moreover, the administrative problems described above with respect to the defined health benefit plan do not exist.

One disadvantage of the defined dollar benefit plan is that it shifts to the employees the risk of health care inflation, making it more difficult for employees to plan with certainty for their retirement. As in the case of the defined health benefit plan, a second disadvantage involves the risk of underfunding and the controversy surrounding overfunding. A third disadvantage is that because the benefit is expressed in terms of dollars, there will be constant pressure to allow the money to be diverted to purposes other than retiree health benefits. This would be similar to the pressure to allow use of qualified retirement plan assets for nonretirement purposes.

An employer could accomplish a similar result to this method (and the method described in [illegible]. below) under present law through the use of a qualified plan. The employer could provide increased qualified retirement plan benefits, and then the retiree could use the benefits to purchase health insurance. Of course, under this method, the tax consequences to the employee would be different because distributions from qualified plans are includible in income.

G. Defined Contribution Plan

The defined contribution plan is similar to the defined dollar benefit plan except that each employee has an account under the plan to which a portion of every employer contribution is allocated, rather than earning the right to an annual dollar benefit. That account grows like a tax-deferred bank account, earning income that is retained in the account. In an employee's retirement, the assets in the account are available to provide health benefits in the same way as the annual dollar benefit under the defined dollar benefit plan.

The advantage of the defined contribution plan is its relative simplicity. The underfunding and overfunding problems do not exist, nor do the administrative problems associated with the defined health benefit plan. Moreover, the employer's obligation is even more limited than under the defined dollar benefit plan in that because the employer is not promising a specific dollar benefit, it bears no risk of poor investment return. In addition, accumulated benefits in a defined contribution plan may not be forfeited if the employee changes jobs, thereby making the retiree health benefits more portable.

The disadvantages of the defined contribution plan generally fall into two categories. First, the employees not only bear the risk of health care inflation, as in the case of the defined dollar benefit plan, but also bear the risk of poor investment return. (This can be mitigated to some extent by the use of a type of defined contribution plan, a "target benefit plan," that adjusts for poor investment return.) This makes it even more difficult for employees to plan efficiently for their retirement. Second, the pressure to allow use of

the trust assets for purposes other than retiree health benefits will be even more acute than with respect to the defined dollar benefit plan. The use of individual accounts makes the plan seem more like a bank account available for any purpose. This lesson can be learned from the qualified retirement plan area in which the pressure for nonretirement use of assets is much more acute in the case of defined contribution plans and individual retirement arrangements (IRA's).

An example of the defined contribution plan is H.R. 2860, introduced by Mr. Chandler on July 1, 1987.

H. Qualified Retirement Plan Surplus Approach

Under the qualified retirement plan surplus approach, excess assets in defined benefit retirement plans are used to fund retiree health benefits. This is achieved by transferring the excess assets to a separate retiree health benefit trust or to a separate account within the retirement plan trust (i.e., a sec. 401(h) account). Under the qualified retirement plan surplus approach, this transfer is not subject to income tax or to the excise tax on reversions (sec. 4980) from retirement plans.

The qualified retirement plan surplus approach generally is combined with one of the four models described above by the use of one of such models in the trust or account to which the excess assets are transferred.

The advantage of the qualified retirement plan surplus approach is that it provides employers with the opportunity to satisfy at least some portion of their retiree health obligations without the use of assets that are easily available for other purposes. Viewed another way, this approach enables employers access to retirement plan surplus without any adverse tax consequences.

One disadvantage of this approach lies in its similarity to the VEBA/sec. 401(h) model. An employer is able to create deliberately a retirement plan surplus. Thus, this approach enables an employer to build a tax-favored fund to use for future retiree health benefits without at the same time providing employees with vested rights to such benefits.

This approach could also undermine the full funding limitation, which caps the amount of deductible contributions that may be made to qualified plans. If assets are transferred from a fully funded plan out of the qualified plan, leaving the plan below the full funding limitation, the employer is entitled to deduct additional contributions that otherwise would not be deductible.

Another disadvantage to this approach is that it may jeopardize the benefit security of the participants in the retirement plan. It is necessary to determine what level of assets should be left in the retirement plan to assure benefit security.

This approach also raises issues as to who the surplus belongs to, the employer or the employees. For example, should te participants in the post-retirement medical benefit plan be the same as the participants in the retirement plan, or can the excess assets be used for the benefit of a completely different group of employees?

Permitting employers to use excess retirement plan assets for this purpose may also create pressure to permit employers to withdraw pension plan assets for other purposes.

Some have argued that the use of excess pension assets to fund retiree health benefits is, at best, a partial solution to the problem of funding such benefits, since it can only be used by a limited number of employers. Thus, it is argued that a more comprehensive funding method would be more appropriate.

It has also been suggested that in the future there are likely to be fewer overfunded pension plans because of the 150 percent of current liability full funding limit enacted in the Revenue Act of 1987. Thus, it has been suggested that this approach is only temporary, and might best be viewed as a stop-gap approach until more comprehensive rules can be enacted.

A second disadvantage of this approach is the concerns it raises about whether the employer or the employees have the right to the excess assets in a retirement plan. Also involved is the question of what are excess assets: how much should be left in the retirement plan to assure benefit security?

An example of the qualified plan surplus approach is H.R. 2781, introduced by Mr. Archer on June 25, 1987.

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